

## An experimental analysis of hypochondriasis

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### Abstract

Hypochondriasis (HC) involves preoccupation with fears of having a serious medical illness based on the misinterpretation of benign bodily perturbations. Individuals with HC also perform behaviors such as checking and reassurance-seeking presumably to reduce health-related fears. Experimental behavioral analyses of HC symptoms, however, are lacking. In the present study, 27 patients with HC were exposed to personally relevant health-related stimuli under one of two conditions: (a) subsequently performing safety-seeking behaviors (e.g., checking) ( $n = 14$ ) or (b) subsequently being instructed *not* to perform such behaviors ( $n = 13$ ). In both groups, subjective anxiety and urges to perform safety behaviors were monitored for 1 h. Results indicated that exposure to the personally relevant health trigger provoked anxiety and urges to perform safety behaviors. For patients who performed such behaviors, these feelings were reduced. For patients who did not, a more gradual reduction of anxiety and urges was observed. Findings are discussed in terms of the conceptualization and treatment of HC behavior, and are relevant to HC's possible relationship to panic and obsessive–compulsive disorder.

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### Introduction

Hypochondriasis (HC), which is categorized as a somatoform disorder in the *DSM-IV-TR* (American Psychiatric Association [APA], 2000), involves a preoccupation with fears of having a serious medical illness based on misinterpretations of bodily sensations. The preoccupations most often associated with HC concern the fear that one may *currently* have a serious disease, but may also be focused on one's risk for developing such a disease at a later time. These preoccupations with illness persist despite appropriate medical evaluation and reassurance, and are commonly associated with *safety behaviors*—responses performed with the aim of protecting one's health. Common safety behaviors in HC include excessive health-related reassurance seeking from physicians, friends, and family; repetitive checking of medical references (e.g., textbooks, the Internet)

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for information on the feared illness; frequent body checking (e.g., use of heart rate and blood pressure monitors); and phobic avoidance of situational triggers (Taylor & Asmundson, 2004).

There have been differing approaches to conceptualizing HC. Some view it as a personality disorder (Tyrer, Fowler-Dixon, Ferguson, & Kelemen, 1990), others see it as a form of neuroticism (e.g., Hiller, Rief, & Fichter, 2002), and still others have conceptualized it functionally as an intense form of health anxiety (Taylor & Asmundson, 2004). Unfortunately, the focus on diagnostic criteria in recent iterations of the *DSM* (since *DSM-III*) is at odds with functional approaches to understanding HC symptoms. Instead, recent *DSMs* advocate a somewhat cursory and superficial view of the disorder as a collection of signs and symptoms with a focus on the body. This is evidenced by the placement of HC among the somatoform disorders in *DSM-IV* (somatoform literally means “mimicking a medical disorder”).

A number of authors have also drawn parallels between the symptoms of HC and those of obsessive-compulsive disorder (OCD; e.g., Fallon, Javitch, Hollander, & Liebowitz, 1991). Specifically, the preoccupations with having a serious illness are considered similar to obsessional thinking in OCD since both are intrusive and persistent; safety behaviors in HC are considered akin to compulsive rituals in OCD as both have a driven and irresistible quality. Yet despite these topographically apparent similarities, little if any experimental work has been carried out to examine whether HC symptoms possess the same *functional* and phenomenological properties that characterize obsessions and compulsive rituals in OCD. In the present study, we sought to clarify this issue.

A series of elegant laboratory studies conducted by Rachman and colleagues elucidated the functional characteristics of obsessions and compulsive rituals in individuals with OCD (for a review, see Rachman & Hodgson, 1980). In these experiments, patients exposed to their obsessional triggers evidenced an immediate increase in anxiety and in their urges to perform specific compulsive rituals (e.g., exposure to contamination evoked urges to wash one’s hands). Although performance of such rituals produced an immediate and striking reduction in both anxiety and urges, patients’ anxiety and urges to ritualize also subsided naturally over a period of time even when prevented from ritualizing. This phenomenon is known as the *spontaneous decay* of compulsive urges (Rachman, de Silva, & Roper, 1976). Thus, the performance of rituals functionally prevents the patient from learning that obsessional anxiety eventually decreases (i.e., extinction occurs) and that rituals are redundant. The result of these studies clarify that compulsive rituals in OCD are negatively reinforced by the immediate reduction in distress they engender, and that the performance of compulsive rituals maintains obsessional fear by preventing its natural extinction.

The results of these studies also elucidate the theoretical underpinning of exposure and response prevention (ERP) treatment for OCD. ERP consists of systematic prolonged confrontation with stimuli which evoke obsessional fear (exposure), along with instructions to refrain from the typically conducted compulsive ritual (response prevention). These procedures demonstrate to the patient that obsessional distress naturally subsides over time, and thus rituals are not necessary. The efficacy of ERP in reducing OCD symptoms is supported by a large body of treatment outcome research (e.g., Abramowitz, 1996).

Despite much theoretical conjecture, experimental behavioral analyses of HC symptoms have not yet been undertaken. Such a systematic study of HC might help clarify (a) the psychological mechanisms involved in the persistence of the disorder, (b) the similarities and differences between HC and OCD, and (c) what treatment procedures might work best for HC. In the present study, we therefore applied an adaptation of the experimental paradigm developed by Rachman and colleagues (e.g., Rachman et al., 1976) to test the following hypotheses regarding HC symptoms: (a) exposure to cues for illness preoccupation will evoke anxiety and urges to perform safety behaviors, (b) completion of safety behaviors will produce an immediate reduction in anxiety and urges, and (c) a more gradual reduction in anxiety and urges will be observed when safety behaviors are not performed after exposure to illness cues.

## Method

### Participants

Study participants were 27 adults who presented to our behavior medicine and anxiety disorders clinics and met *DSM-IV-TR* criteria for HC (assessment procedures are described below). Other inclusion criteria were

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